

§ 728.33 Nonavailability statement (DD 1251).

(a) *General.* Per DODINST 6015.19 of 26 Nov. 1984, the following guidelines are effective as of 1 Jan. 1985. All previously issued Nonavailability Statement guidelines and reporting requirements are superseded.

(b) *Applicability.* The following provisions are applicable to nonemergency inpatient care only. A DD 1251 is not required:

(1) For emergency care (see paragraph (d)(1)) of this section.

(2) When the beneficiary has other insurance (including Medicare) that provides primary coverage for a covered service.

(3) For medical services that CHAMPUS clearly does not cover.

(c) *Reasons for issuance.* DD 1251's may be issued for only the following reasons:

(1) Proper facilities are not available.

(2) Professional capability is not available.

(3) It would be medically inappropriate (as defined in § 728.2(u)) to require the beneficiary to use the USMTF and the attending physician has specific prior approval from the facility's commanding officer or higher authority to make such determination.

(i) Issuance for this reason should be restricted to those instances when denial of the DD 1251 could result in a significant risk to the health of any patient requiring any clinical specialty.

(ii) Issuing authorities have discretionary authority to evaluate each situation and issue a DD 1251 under the "medically inappropriate" reason if:

(A) In consideration of individual medical needs, personal constraints on an individual's ability to get to the USMTF results in an unreasonable limitation on that individual's ability to get required medical care, and

(B) The issuing authority determines that obtaining care from a civilian source selected by the individual would result in significantly less limitations on that individual's ability to get required medical care than would result if the individual was required to obtain care from a USMTF.

(C) A beneficiary is in a travel status. The commanding officer of the first facility contacted, in either the bene-

ficiary's home catchment area or the catchment area where hospital care was obtained, has this discretionary authority. Travel in this instance means the beneficiary is temporarily on a trip away from his or her permanent residence. The reason the patient is traveling, the distance involved in the travel, and the time away from the permanent residence is not critical to the principle inherent in the policy. The issuing officer to whom the request for a Nonavailability Statement is made should reasonably determine that the trip was not made, and the civilian care is not (was not) obtained, with the primary intent of avoiding use of a USMTF or USTF serving the beneficiary's home area.

(d) *Guidelines for issuing—(1) Emergency care.* Emergency care claims do not require an NAS; however, the nature of the service or care must be certified as an emergency by the attending physician, either on the claim form or in a separate signed and dated statement. Otherwise, a DD 1251 is required by CHAMPUS-eligible beneficiaries who are subject to the provisions of this section.

(2) *Emergency maternity care.* Unless substantiated by medical documentation and review, a maternity admission would not be deemed as an emergency since the fact of the pregnancy would have been established well in advance of the admission. In such an instance, the beneficiary would have had sufficient opportunity to obtain a DD 1251 if required in her residence catchment area.

(3) *Newborn infant(s) remaining in hospital after discharge of mother.* A newborn infant remaining in the hospital continuously after discharge of the mother does not require a separate DD 1251 for the first 15 days after the mother is discharged. Claims for care beyond this 15-day limitation must be accompanied by a valid DD 1251 issued in the infant's name. This is due to the fact that the infant becomes a patient in his or her own right (the episode of care for the infant after discharge of the mother is not considered part of the initial reason for admission of the mother (delivery), and is therefore considered a separate admission under a different diagnosis).

(4) *Cooperative care program.* When a DD 2161, Referral for Civilian Medical Care, is issued for inpatient care in connection with the Cooperative Care Program (§ 728.4(z)(5)(iv)) for care under CHAMPUS, a DD 1251 must also be issued.

(5) *Beneficiary responsibilities.* Beneficiaries are responsible for determining whether an NAS is necessary in the area of their residence and for obtaining one, if required, by first seeking nonemergency inpatient care in the USMTF or USTF serving the catchment area. Beneficiaries cannot avoid this requirement by arranging to be away from their residence when nonemergency inpatient care is obtained, e.g., staying with a relative or traveling. Individuals requiring an NAS because they reside in the inpatient catchment area of a USMTF or USTF also require an NAS for non-emergency care received while away from their inpatient catchment area.

(e) *Issuing authority.* Under the direction of the Commander, Naval Medical Command, exercised through commanders of naval geographic medical commands, naval MTFs will issue Non-availability Statements only when care required is not available from the naval MTF and the beneficiary's place of residence is within the catchment area (as defined in § 728.2(d)) of the issuing facility or as otherwise directed by the Secretary of Defense. When the facility's inpatient catchment area overlaps the inpatient catchment area of one or more other USMTFs or USTFs with inpatient capability and the residence of the beneficiary is within the same catchment area of one or more other USMTFs or USTFs with inpatient capability, the issuing authority will:

(1) Determine whether required care is available at any other USMTFs or USTFs whose inpatient catchment area overlaps the beneficiary's residence. If care is available, refer the beneficiary to that facility and do not issue a DD 1251.

(2) Implement measures ensuring that an audit trail related to each check and referral is maintained, including the check required before retroactive issuance of a DD 1251 as delineated in paragraph (g) of this section.

When other than written communication is made to ascertain capability, make a record in the log required in paragraph (h) of this section that "Telephonic (or other) determination was made on (date) that required care was not available at (name of other USMTF(s) or USTF(s) contacted)". The individual ascertaining this information will sign this notation.

(3) Once established that a DD 1251 is authorized and will be issued, the following will apply:

(i) Do not refer patients to a specific source of care.

(ii) *Nonavailability Statements* issued at commands outside the United States are not valid for care received in facilities located within the United States. Statements issued within the United States are not valid for care received outside the United States.

(iii) The issuing authority will:

(A) If capability permits, prepare a DD 1251 via the automated application of DEERS. Where this system is operational, it provides for transmitting quarterly reports to the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)) by electronic means. System users should refer to their DEERS/NAS Users Manual for specific guidance on the use of the automated system. At activities where the DEER/NAS automated system is not operational, prepare each DD 1251 per instructions on the reverse of the form. After completion, if authorized by the facility CO, the issuing authority will sign the DD 1251. Give a copy to the patient for presentation to a participating civilian provider, or for submission with the claim of a non-participating provider. Retain a copy for the issuing activity's records. Retain the original for subsequent transmittal to the Naval Medical Data Services Center per paragraph (j) of this section.

(B) Explain to the patient or other responsible family member the validity period of the DD 1251 (see paragraph (f) of this section).

(C) Ensure that beneficiaries are clearly advised of the cost-sharing provisions of CHAMPUS and of the fact that the issuance of a Nonavailability Statement does not imply that CHAMPUS will allow any and all costs

incurred through the use of the DD 1251. The issuance of a DD 1251 indicates only that care requested is not available at a USMTF or USTF serving the beneficiary's residence inpatient catchment area.

(D) Review, with the patient or responsible family member, instructions 1 through 6 on the face of the DD 1251 and have the patient or responsible family member sign acknowledgement that such review has been made and is understood.

(E) Advise recipients that CHAMPUS fiscal intermediaries may deny claims of individuals who are not enrolled in the Defense Enrollment Eligibility Reporting System (DEERS).

(f) *Validity period.* DD 1251's issued for:

(1) Other than maternity care are valid for a hospital admission occurring within 30 days of issuance and remain valid from the date of admission until 15 days after discharge from the facility rendering inpatient care. This allows for any follow-on treatment related directly to the original admission.

(2) Maternity episodes are valid if outpatient of inpatient treatment related to the pregnancy is initiated within 30 days of its issuance. They remain valid for care of the mother through termination of the pregnancy and for 42 days thereafter to allow for postnatal care to be included in the maternity episode. (See paragraph (d)(3) of this section for the validity period of DD 1251's for infants remaining after discharge of the mother.)

(g) *Retroactive issuance.* Issue Non-availability Statements retroactively only if required care could not have been rendered in a USMTF or USTF as specified in paragraph (e) of this section at the time services were rendered in the civilian sector. At the time a retroactive issuance is requested, the facility receiving the request will determine whether capability existed at the USMTF or USTF serving the inpatient catchment area wherein the beneficiary resides (resided) or at any of the facilities in the overlapping area described in paragraph (e) of this section. While the date of service will be recorded on the DD 1251, send the retained original to the Naval Medical

Data Services Center along with others issued during the week of issuance (paragraph (j) of this section refers).

(h) *Annotating DD 1251's.* Before issuance, annotate each DD 1251 per the instructions for completion on the reverse of the form. DD 1251's issued under the CO's discretionary authority for the "medically inappropriate reason (paragraph (c)(3)(ii) of this section) will be annotated in the remarks section documenting the special circumstances necessitating issuance, the name and location of the source of care selected by the beneficiary, and approximate distance from the source selected to the nearest USMTF or USTF with capability (see instruction number 2 on the reverse of the DD 1251). Establish and maintain a consecutively numbered log to include for each individual to whom a DD 1251 is issued:

(1) Patient's name and identifying data.

(2) The facility unique NAS number (block number 1 on the DD 1251).

(i) *Appeal procedures.* Beneficiaries may appeal the denial of their request for a DD 1251. This procedure consists of four levels within Navy, any one of which may terminate action and order issuance of a Nonavailability Statement if deemed warranted:

(1) The first level is the chief of service, or director of clinical services if the chief of service is the cognizant authority denying the beneficiary's original request.

(2) The second level is the commanding officer of the naval MTF denying the issuance. Where the appeal is denied and denial is upheld at the commanding officer's level, inform beneficiaries that their appeal may be forwarded to the geographic commander having jurisdictional authority.

(3) The third level is the appropriate geographic commander, if the appeal is denied at this level, inform beneficiaries that their appeal may be forwarded to the Commander, Naval Medical Command, Washington, DC 20372-5120.

(4) The Commander, Naval Medical Command, the fourth level of appeal, will evaluate all documentation submitted and arrive at a decision. The beneficiary will be notified in writing

of this decision and the reasons therefor.

(j) *Data collection and reporting.* Do not issue the original of each DD 1251 prepared at activities where the DEER/NAS automated system is not operational. Send the retained originals to the Commanding Officer, Naval Medical Data Services Center (Code-03), Bethesda, MD 20814-5066 for reporting under report control symbol DD-HA (Q) 1463(6320).

§ 728.34 Care beyond the capabilities of a naval MTF.

When either during initial evaluation or during the course of treatment of an individual authorized care in this subpart, a determination is made that required care or services are beyond the capability of the naval MTF, the provisions of § 728.4(z)(2) apply.

§ 728.35 Coordination of benefits—third party payers.

Title 10 U.S.C. 1095 directs the services to collect from third-party payers the reasonable costs of inpatient hospital care incurred by the United States on behalf of retirees and dependents. Naval hospital collection agents have been provided instructions relative to this issue and are responsible for initiating claims to third-party payers for the cost of such care. Admission office personnel must obtain insurance, medical service, or health plan (third-party payer) information from retirees and dependents upon admission and forward this information to the collection agent.

§ 728.36 Pay patients.

Care is provided on a reimbursable basis to retired Coast Guard officers and enlisted personnel, retired Public Health Service Commissioned Corps officers, retired Commissioned Corps officers of the National Oceanic and Atmospheric Administration, and to the dependents of such personnel. Accordingly, patient administration personnel will follow the provisions of subpart J to initiate the collection action process when inpatient or outpatient care is provided to these categories of beneficiaries.

Subpart E—Members of Foreign Military Services and Their Dependents

§ 728.41 General provisions.

(a) *Dependent.* As used in this subpart, the term “dependent” denotes a person who bears one of the following relationships to his or her sponsor:

- (1) A wife.
- (2) A husband if dependent on his sponsor for more than one-half of his support.
- (3) An unmarried legitimate child, including an adopted or stepchild who is dependent on the sponsor for over one-half of his or her support and who either:
 - (i) Has not passed the 21st birthday; or
 - (ii) Is incapable of self-support due to a physical or mental incapacity that existed prior to reaching the age of 21; or
 - (iii) Has not passed the 23rd birthday and is enrolled in a full-time course of study in an accredited institution of higher learning.

(b) *Transfer to naval MTFs in the United States.* Do not transfer personnel covered in this subpart to the United States solely for the purpose of obtaining medical care at naval MTFs. Consideration may be given however, in special circumstances following laws of humanity or principles of international courtesy. Transfer to naval MTFs in the United States of such persons located outside the United States requires approval of the Secretary of the Navy. Naval commands, therefore, should not commit the Navy by a promise of treatment in the United States. Approval generally will not be granted for treatment of those who suffer from incurable afflictions, who require excessive nursing or custodial care, or those who have adequate facilities in their own country. When a request is received concerning transfer for treatment at a naval MTF in the United States, the following procedures apply:

- (1) Forward the request to the Chief of Naval Operations (OP-61), with a copy to the Commander, Naval Medical Command, Washington, DC 20372-5120 for administrative processing. Include: